June 8th, 2026
To: Oregon Health Authority Behavioral Health Committee
From: Oregon Pediatric Improvement Partnership

Hello, my name is Colleen Reuland, and I am the Director of the Oregon Pediatric Improvement Partnership (OPIP). We have led work across this wonderful state of Oregon over the last twenty years, focused on improving the health of all children in Oregon through the provision of high-quality health care. Our work has included an explicit focus on behavioral health services for children, spanning from young children to adolescents. OPIP has worked with and learned from nearly every CCO in Oregon. We have heard from parent & youth advisors and family advocacy organizations across the state and provided front-line implementation support to primary care & behavioral health providers that contract with all 16 CCOs. We also facilitate the OPIP Partners, a committee of public and private stakeholders committed to improving the health of children in Oregon, which meets quarterly and has recently focused on how to address learnings from the implementation of CCOs since 2013, gaps in federally required care, and opportunities to address these gaps in the next iteration of Coordinated Care Organizations (CCOs). We are providing public testimony today that is rooted in these experiences, to share feedback about what should be prioritized in the CCO procurement process related to behavioral health.

We appreciate the Behavioral Health Committee's commitment to improving the quality of behavioral health services in Oregon and its review of Exhibit M of the 2026 OHA CCO Medicaid Contract. Given that a majority of children are insured through Medicaid in Oregon, and nine of out ten of them are in CCOs, this is a particularly important lever for ensuring that children receive federally required EPSDT care and that we are addressing issues early on to promote health and development. Since the implementation of CCOs in 2013, we have learned that a global budget for all populations and current network adequacy reporting have resulted remaining lack of network adequacy for children and adolescents and in EPSDT aligned care not being provided to insured children. CCOs continue to and have recently increased a focus on prioritizing higher-acuity, downstream outpatient services, while young children and families often need access to EPSDT aligned, low-acuity, outpatient behavioral health services that provide early intervention and prevent more intense needs from developing.

We ask you please consider the following in providing feedback to OHA on the overall CCO procurement process and specifically on Exhibit M of the contracting process.

Address the Lack of Behavioral Health Network Adequacy for Children and Adolescents that is the Foundational Principle Upon which the Global Budget Is Provided

- **Part 1** of Exhibit M states that CCOs are responsible for maintaining adequate provider networks and ensuring timely access to services.
- As we have heard in input sessions and have quantitative data to confirm, there is not network adequacy within CCOs for children's behavioral services, particularly in outpatient settings and for children birth to five. This is expected to get worse as CCOs are addressing cost by restricting their networks and prioritizing providers of high-cost care and patients with high complexity.
- We strongly recommend Exhibit M has increased language around how to ensure network adequacy documentation for these specific populations that needs to be provided ensure specificity for the populations. This could be done by requiring network adequacy documentation for specific populations: we recommend birth to 5 and ages 6–21, recognizing their distinct needs. For school aged populations, we recommend requiring contracting for applicable services within schools to ensure network adequacy and services in places children can easily access.

Ensure CCOs Provide Sustainable Payment and Support Network Adequacy Through Integration of Services in Primary Care and School Based Settings.

- **Part 3** of Exhibit M emphasizes the importance of integrating physical, oral and behavioral health care.
- We strongly support this focus. Research and family feedback consistently demonstrate the value of delivering behavioral health services in primary care and school-based settings, where children and families are most likely to access care.
- However, most integrated behavioral health programs currently do not serve young children, and existing CCO payment models often create barriers to the sustainable integration of behavioral health services within primary care. Addressing these barriers will be critical to expanding access for young children and their families.
- Secondly, there are a number of administrative and financing barriers to ensuring services within schools are provided and appropriately supported by CCOs that should be considered.

Ensure Global Budget Funds for Children/Adolescents Go to Services for This Population

We recommend that your feedback on Exhibit M includes feedback that addresses the unintended negative consequences of a global budget that allows funds for children to be shifted to high-cost adults.

- Ensure behavioral health funding intended for children is used for pediatric services by requiring CCOs to report expenditures by both service type and population served.
- The Global Budget should appropriately support behavioral health care in primary care settings, which provide approximately 70% of behavioral health services for young children. Ensure **services are covered** by applicable providers. (e.*g. Some public payors didn't pay when in primary care)*
- Address the sustainable payment barriers in future CCO contract requirements (ex. Ensure services are covered by applicable providers, require CCOs to pay DMAP rates for all provider types, require CCOs to pay OHA FFS rates for Primary Care-Based Behavioral Health and require PMPMs to sustain Integrated Behavioral Health in Primary Care, Enhance VBP requirements that are specific to behavioral health like those used for PCPCH).

Thank you for consideration of these issues as you finalize your recommendations for Exhibit M of the CCO Medicaid Contract. OPIP is eager to support improvements and serve as a partner in these complex times.

Colleen Reuland, MS
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If you would like to learn more about the public comments and issue briefs we have provided related to this topic, please see our website, and we have provided a sampling of below:

- Oregon Pediatric Improvement Partnership (OPIP) Partners Committee Recommendations to OHA on Ensuring Quality of Care for Children in the Oregon's 1115 Waiver and CCO 3.0
- OPIP Partner Learnings on Behavioral Health and EPSDT Services for Children – April 2026
- Learnings Related to Behavioral Health Network Adequacy for Children Birth to Five in Coordinated Care Organizations & Opportunities for Improvements
- Key Learnings from Oregon TPEC: Advancing Behavioral Health for Young Children – April 2026
- Public Comment to the Oregon Health Policy Board on EPSDT and Behavioral Health Services for Children – September 2025
- Public Comment to the Oregon Health Policy Board on CCO 3.0 – April 2025
- Public Comment to the Early Learning Council on Addressing the Behavioral Health Needs of Young Children – April 2025